STATE OF HAWAII
CRIME VICTIM COMPENSATION COMMISSION
333 Queen Street, Room 404
Honolulu, Hawaii 96813
Telephone: 808 587-1143
FAX 808 587-1146

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This is to authorize _____,
Complete Name of(Medical Provider) Doctor, Dentist, Hospital, etc

_____,
Complete Street Address

_____
City State Zip Code

to disclose information regarding:

_____ (DOB: ____/____/____) Case No: _____,
(Victim's Name)

This request is based on an injury which occurred on _____.

The information is limited to service dates from _____ to _____.

The information is for the purpose of determining eligibility for compensation with the Crime Victim Compensation Commission.

This consent may be applicable to alcohol or drug abuse, sexually transmitted diseases and psychiatric medical reports as well as other medical records.

This consent may be revoked at any time, upon written notice from the person who signed below.

Federal Public Law 103-322 (H.R. 3355) Section 230202, provides that the Commission should be considered last payor and not a third party liability.

_____ _____
Date SIGNATURE of patient or person authorized to sign on behalf and their relationship to the patient.

Requests for additional information and completed forms should be directed to the above address.